STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, Ca 95814

November 14, 1986

ALL-COUNTY INFORMATION NOTICE NO. I-103-86

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: VETERANS' BENEFITS VERIFICATION AND REFERRAL (CA 5)

REFERENCE:

Attached is a copy of the revised Form CA 5, Veterans' Benefits Verification and Referral. The CA 5 was revised to accommodate the collection of additional information to allow the County Veteran Service Offices (CVSO) and county Medi-Cal staff to more accurately determine veteran benefit amounts and Medi-Cal share of costs, respectively.

Input for this revision was received from the CVSO, County Forms Advisory Committee, and the Medi-Cal Eligibility and Health Recovery units. The most significant changes made to the form are:

1. Addition of spaces for the veteran's date of death, place of death, and branch of service.

2. Addition of spaces for the claimant's relation, birthdate, and Social Security number.

3. Addition of a section for requesting "Aid and Attendance Determination" (Medi-Cal Only cases).

4. A requirement for the CVSO to send one completed copy to the Health Services Recovery Branch Insurance Unit when Aid and Attendance benefits have been granted (Medi-Cal Only cases).

5. Printed on five-part NCR paper rather than four-part.

As in the past, a CA 5 should not be initiated unless one of the following is provided:

1. Veteran's Social Security number and date of birth;

2. Veteran's military serial number; or

3. VA claim number.

Without one of the above identifiers, the Veterans Administration will not be able to identify the veteran or process the referral.

Counties should continue to make an entry in the "County Use Only" section of the Form CA 2 (Statement of Facts Supporting Eligibility for Assistance), or the MC 210 (Statement of Facts-Medi-Cal), or the "Eligibility Worker Only" section of the Form FC 2 (Statement of Facts Supporting Eligibility for AFDC-FC) as to why the referral was not made (e.g., the recipient is unable to provide identification numbers).

The current CA 5 (7/83) will continue to be used until supplies are exhausted. Supplies of the revised CA 5 (11/86) are expected to be available about January 1987. The attached advance copy is being provided to allow counties the time, if needed, to train staff and, if applicable, print their own forms. Regular supplies of the revised CA 5, when available, may be obtained by sending Form GEN 727B to the DSS Warehouse, P.O. Box 22429, Sacramento, Ca 95822-3799.

As with all new or revised AFDC forms your comments or suggestions for future improvement are welcome.

Please forward comments to:

AFDC Forms Coordinator
AFDC and Food Stamp Policy Implementation Bureau
State Department of Social Services
744 P Street, Mail Station 16-31
Sacramento, Ca 95814

If you have questions about how to use the revised CA 5 related to the AFDC Program, please contact the AFDC and Food Stamp Policy Implementation Bureau at (916) 322-5330. Questions regarding use in the Medi-Cal Program should be addressed to Ms. Teri Hodges, Medi-Cal Policy Section at (916) 324-4972.

ROBERT A. HOREL
Deputy Director

Attachment

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

VETERANS' BENEFITS VERIFICATION AND REFERRAL

NOTE: DO NOT *COMPLETE THIS FORM UNLESS ONE OF THE FOLLOWING IS KNOWN: VETERAN'S SOCIAL SECURITY NO.* **AND** *DATE OF BIRTH, MILITARY SERIAL NO., OR VETERANS ADMINISTRATION (V.A.) CLAIM NO.*

Instructions on Reverse

Original and three copies: *County Veterans Service Office*

One copy: *Case File*

Social Security Number (SSN) — You must provide the veteran's SSN, if known, to assist in the evidence gathering process and to explore potential benefits. The furnishing of the SSN of family members is a condition of eligibility required by Section 402(a)(25) (AFDC) and Section 1137(a)(Medi-Cal) of the Social Security Act. Failure to cooperate may result in denial or discontinuance of aid as required by MPP Sections 40-157 and 44-103 (AFDC) and Title 22, CAC Section 50168 (Medi-Cal).

Enter Name and Address of County Veterans Service Office

ELIGIBILITY WORKER (PLEASE PRINT)	
WORKER NUMBER	TELEPHONE NUMBER
CASE NAME	
CASE NUMBER	APPLICANT/RECIPIENT PHONE NO.

☐ Please verify any VA benefits being received by veteran/dependant including Aid and Attendance (A and A), if applicable.

☐ Please determine veteran's/dependent's eligibility for veterans' benefits (see below if requesting A and A).

I

1 VETERAN'S NAME (LAST, FIRST, MIDDLE)	BIRTHDATE	BIRTHPLACE	LIVING? ☐ YES ☐ NO
FOR FG/U ONLY IN HOME? ☐ YES ☐ NO	VETERAN'S ADDRESS (NUMBER, STREET, CITY, STATE, ZIP CODE)	DATE OF DEATH	PLACE OF DEATH
V.A. CLAIM NO.	SOCIAL SECURITY NUMBER	MILITARY SERIAL NUMBER	DATE ENTERED SERVICE / DATE DISCHARGED / BRANCH OF SERVICE

	NAME OF CLAIMANT	RELATIONSHIP	BIRTHDATE	SOCIAL SECURITY NUMBER	ADDRESS
2					
3					
4					

II **REQUEST FOR AID AND ATTENDANCE DETERMINATION FOR MEDI-CAL (MA) ONLY CASES** ☐ VETERAN ☐ WIDOW ☐ PARENT

MEDI-CAL I.D. NUMBER			SHARE OF COST	EFFECTIVE DATE
			$	

	SSA	CIVIL SERVICE	OTHER		SSA	CIVIL SERVICE	OTHER
VETERAN'S MONTHLY GROSS INCOME	$	$	$	WIDOW'S/PARENT'S MONTHLY GROSS INCOME	$	$	$

LIVING IN: ☐ NURSING FACILITY ☐ INDEPENDENT LIVING SITUATION

NAME AND ADDRESS OF NURSING FACILITY

AUTHORIZATION FOR RELEASE OF INFORMATION

III *I hereby authorize the welfare department to release the above information to the County Veterans Service Office and the Veteran's Administration for purposes of identifying or obtaining benefits available to the persons identified above. I also authorize the County Veterans Service Officer and Veteran's Administration to release their findings (to be noted below).*

SIGNATURE (OR MARK) OF VETERAN/DEPENDENT/FC REP.	DATE	SIGNATURE OF WITNESS TO MARK	DATE

IV —TO BE COMPLETED BY COUNTY VETERANS SERVICE OFFICE—

	1-Veteran	2-Claimant	3-Claimant	4-Claimant
Monthly Benefit	$	$	$	$
Beginning Date (Month/Day/Year)				
Ending Date (Month/Day/Year)				
Lump Sum Payment Past 6 Months	$	$	$	$

If Monthly Benefit is being paid, please check:

- ☐ Compensation
- ☐ Pension
- ☐ Other (see Remarks section)
- ☐ Includes A and A benefits of $ _____

Eligibility Status: (Please check)

- ☐ No Basic Eligibility
- ☐ Claim Initiated
- ☐ Claim Being Reviewed
- ☐ Claim Denied

Remarks:

Enter Name and Address of County Welfare Department

FROM:

VETERANS SERVICE REPRESENTATIVE (PRINT)	
TELEPHONE NO.	DATE

INSTRUCTIONS FOR COUNTY USE AND COMPLETION OF VETERAN'S BENEFITS VERIFICATION AND REFERRAL FORM CA 5

Form CA 5 is mandatory; no substitute permitted

USE FORM CA 5:

1. To verify the amount or status of veterans' benefits being received by any AFDC or Medi-Cal applicant or recipient.

2. To refer applicants or recipients to the County Veterans Service Office to obtain new veteran benefits when information on the CA 2 (Statement of Facts Supporting Eligibility for Assistance) or the FC 2 (Statement of Facts Supporting Eligibility for AFDC-FC) or the MC 210 (Statement of Facts - Medi-Cal) indicates possible eligibility for benefits.

DO NOT SEND FORM CA 5 WHEN:

1. The Serviceperson is still on active duty, or

2. None of the following is known: 1) Veteran's Social Security Number (SSN) AND date of birth; 2) Veteran's Military Serial Number; or 3) V.A. Claim Number.

If either of the above applies, DO NOT initiate a CA 5. DO make an entry in the "COUNTY USE ONLY" section of the Form CA 2, Form MC 210 or the "ELIGIBILITY WORKER ONLY" section of the Form FC 2, stating why a referral was not made.

INSTRUCTIONS FOR COMPLETION OF FORM CA 5:

Enter name and address of County Veterans Service Office (CVSO) in upper left corner address box.

Enter name and address of County Welfare Department (CWD) in lower left corner address box.

Enter worker and applicant/recipient case information in upper right corner boxes.

Check the appropriate request box to verify or determine benefits.

Section I — Enter all known veteran and, if applicable, claimant information. At least one of the following is required: 1) Veteran's SSN **and** date of birth; 2) Veteran's military serial number; or 3) VA claim number.

Section II — Complete this section only for Medi-Cal (MA) cases. Completion of this section is not required for AFDC or AFDC-FC cases.

Section III — Have the veteran, dependent/claimant or foster care representative read, sign and date the authorization statement (attach copy of placement order in foster care cases).
Have the veteran, dependent/claimant, or foster care representative hand carry 4 copies of the form along with medical documents, military papers, etc., to the CVSO. Referral by mail may be used if hand carry method is not possible.

Section IV — This section will be filled in by the CVSO.

DISTRIBUTION OF FORM CA-5:

Five copies of the form are to be filled out and the original plus three copies are to be sent to the County Veterans Service Office. One copy shall be retained in the case file until the original is completed and returned by the County Veterans Service Office. The completed original shall then be retained as a permanent record in the welfare department. **ONE COPY IS TO BE SENT BY THE COUNTY VETERANS SERVICE OFFICE TO THE DEPARTMENT OF HEALTH SERVICES RECOVERY BRANCH HEALTH INSURANCE UNIT 105, P.O. BOX 1287, SACRAMENTO, CA. 95806; ONLY IF VA AID AND ATTENDANCE BENEFITS HAVE BEEN GRANTED TO THE VETERAN, WIDOW, OR PARENT.** One copy will be returned to the welfare department after any further actions are completed. The remaining copy will be retained in the County Veterans Service Office.